Attachment 6

STATE REVIEW TEAM REFERRAL BATCH SHEET

LDSS Office Name_____ Page_____ of _____

Print LDSS Office Name. **Do NOT list the LDSS District office number**

_____/_____/_____
Date Submitted to SRT

_____
LDSS Staff Name First Last (Print)

LDSS Staff
Telephone Number: (_____) _____-_____

_____/_____/_____
Date Received in SRT

_____
SRT Staff Name First/Last (Print)

CUSTOMER NAME (PRINT)	SOCIAL SECURITY NUMBER	CLIENT ASSISTANCE UNIT NUMBER	SRT USE ONLY REFERRAL INCLUDED	
			YES	NO

_____/_____/_____
Date Returned to LDSS

_____
SRT Staff Name First /Last (Print)

SRT Staff telephone number:_____

DHR/FIA 210 (10/10)

STATE REVIEW TEAM REFERRAL BATCH SHEET INSTRUCTIONS

Local Department of Social Services

1. LDSS Office Name: **Print** the name of the local department office.
   - Examples: Montgomery County – Rockville
     Prince George's County – Hyattsville
     Hilton Heights
2. Page __ of __: List number of pages submitted
   - Examples: Page 1 of 1
     Page 2 of 3
3. Date Submitted to SRT: List the Month/Day/Year of the day the referrals are being sent to the SRT.
4. LDSS staff name: **Print** the name of the LDSS staff responsible for completing the form LDSS staff telephone number: The direct telephone number for the LDSS contact person regarding referrals listed on the completed form.
5. Print the customer's name (First then last name) for each referral sent with the completed SRT referral batch sheet form. (Check to ensure the correct spelling is provided for each customer listed.
6. List the social security number (SSN) for each customer listed. If the customer does not have a SSN write the word **None** in the column for SSN.
7. Client Assistance Unit Number: List the customer's AU number for the application period the disability determination is required.

Note: Complete all information on each page. (Including LDSS office name, date submitted to SRT, LDSS staff name and telephone number). Each listed case must include the appropriate 9-digit AU number.

State Review Team

1. Date Received in SRT: List the Month/Day/Year the SRT referral batch sheet and referrals are received by SRT.
2. SRT staff name: Print the first and last name of the SRT staff verifying the information and receipt of the referral packets listed on the batch sheet.
3. Referral Received (YES/NO): Place an X in the appropriate column to indicate if the referral whether the listed referral was received.
4. Date Returned to LDSS: List the Month/Day/Year the batch sheet is returned to the LDSS office.
5. Make a copy of the batch sheet after notating whether each referral listed on the batch sheet was received.
6. File the copy of the batch sheet in the assigned binder.
7. Return the original batch sheet to the LDSS.

Note: SRT staff will check for receipt of all referrals listed on the batch sheet received from the local department. SRT will contact the LDSS regarding any discrepancies.

Attachment 7

CUSTOMER DECLARATION OF DISABILITY FORM

LOCAL DEPARTMENT USE ONLY
AU#
CLIENT ID#

Please complete all sections (front and back) of this form and sign where indicated. If you need help completing this form, please contact your case manager at: _____ and have the form with you when you call. You **must** return the completed form to the person and address below.

Case Manager Name _____

First **Last**

Local Department Address _____

_____

City **State** **Zip Code**

If the person completing this form is someone other than the disabled person, please complete the following information:

Name _____

Relationship to Disabled Person _____

Daytime Phone Number _____

Address _____

_____

City **State** **Zip Code**

SIGN HERE _____ **DATE** _____

YOUR SIGNATURE

TO BE COMPLETED BY THE DISABLED PERSON:

Name _____
Last **First**

Social Security Number _____ **Date of Birth** _____

Address _____

_____
City **State** **Zip Code**

1. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since **you last applied for Social Security disability benefits?** ☐Yes ☐No
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

2. Do you have any new physical or mental limitations as a result of your illnesses, injuries or conditions **since you last applied for Social Security disability benefits?** ☐Yes ☐No
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

3. Do you have any new illnesses, injuries or conditions **since you last applied for Social Security disability benefits?** ☐Yes ☐No
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

SIGN HERE _____ **DATE** _____
YOUR SIGNATURE

LOCAL DEPARTMENT OF SOCIAL SERVICES

INSTRUCTIONS

The Local Department Case Manager must:

- Complete the information at the top of page 1;
- Give or mail the form to the applicant for completion; and
- Include the completed form with all SRT referral packets.

NOTE: All individuals applying for Medical Assistance based on being Blind or Disabled must complete and return the Customer Declaration of Disability form.

Attachment 8

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
REQUEST FOR INFORMATION TO VERIFY ELIGIBILITY

1. LOCAL DEPARTMENT	2. DATE
	3. CASE NAME
	4. CATEGORY & AU NUMBER
	5. CASE MANAGER
	6. TELEPHONE NUMBER

DEAR APPLICANT/RECIPIENT:

To get benefits you must give us the proofs **MARKED BELOW** for you and **ALL PERSONS FOR WHOM YOU ARE APPLYING**. If you have any questions or need help to get the proofs, please call me. Thank you.

☐ Bring the proofs to an interview…
☐ Bring or send them to me no later than… DATE:

	PROOF OF INCOME		PROOF OF IDENTITY		MOST RECENT PROOF OF EXPENSES BILLED OR PAID BY YOU OR OTHERS FOR YOUR HOUSEHOLD
☐	Pay stubs – last _____	☐	Social Security Cards	☐	Heat, Lights, Telephone, Water, Sewage, Trash Removal, Other Utilities
☐	Statement on Employer's Letterhead	☐	Birth or Baptismal Certificates	☐	*Rent Mortgage Receipts
☐	Tax Return 20_____	☐	Drivers Licenses	☐	*Amount of Shared Expenses
☐	Unemployment Benefits	☐	Alien Registrations	☐	*Child or Adult Dependent Care
☐	Union/Strike Benefits	☐	Marriage License/Divorce Decree	☐	Property Taxes/Homeowners Insurance
☐	Child Support or Alimony	☐		☐	Medical Bills
☐	Social Security Benefits	☐		☐	
☐	SSI/SSDI Benefits	☐		☐	
☐	Veteran's Benefits or Other Pensions		PROOF OF ASSETS		OTHER PROOFS
☐	Education Loans/Grants/Scholarships	☐	Checking and Savings Accounts	☐	School Attendance and Financial Aid Form 604 or 690
☐	Military Allotments	☐	Certificates of Deposit (CD's, IRA's and Keogh Accounts)	☐	Address of Absent Parents
☐	*Payments From Others for Expenses	☐	Stocks, Bonds, Mutual Funds	☐	Pregnancy/Prenatal Care
☐	*Contributions Received	☐	Dividends and Interest	☐	Disability Incapacitation
☐	*From Roomers or Boarders	☐	Life and Health Insurance	☐	Application for Other Benefits
☐	Rental/Mortgage Income	☐	Cars and Other Vehicle Loans	☐	Proof of Who Lives With You
☐	Self Employment Tax Records	☐	Make, Model and Year for all Cars, Trucks, & Other Licensed Vehicles	☐	Report Cards
☐	Workman's Compensation	☐	Transferred Assets in Last 3 Months	☐	Health Care Forms
☐	Wage Form	☐	Property: House, Land, Other	☐	Type of Housing
☐		☐		☐	

***IMPORTANT**: These proofs must include the name, address and telephone numbers of the persons making the statement.

OTHER INSTRUCTIONS with Box Reference Number:

SUBSTANTIAL GAINFUL ACTIVITY WORKSHEET

Name of Disabled Person: ______________________ **Social Security Number:** ______________

Disability: ☐ Blindness ☐ Other

1. **Gross Earned Income** (Please attach verification) $ ____________ per month

2. **Employer Subsidy** (if any) included in your pay (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) $ ____________ per month

3. **Impairment-Related Work Expenses** per month (see attached for description)
   - a. Attendant Care Services $ ____________
   - b. Transportation Costs ____________
   - c. Medical Devices ____________
   - d. Work-Related Equipment ____________
   - e. Prosthesis ____________
   - f. Residential Modifications ____________
   - g. Routine Drugs and Routine Medical Services ____________
   - h. Diagnostic Procedures ____________
   - i. Nonmedical Applications and Devices ____________
   - j. Assistants (e.g., if visually impaired, cost to hire reader) ____________
   - k. Other Items and Services ____________

++

Office Use only (Case Manager complete below)

4. **TOTAL Impairment-Related Work Expenses**

   Add together all that apply (total of 3a through 3k) $ ____________ per month

5. **Net Countable Earnings** (from 1 subtract 2 and 4) $ ____________ per month

- Are current countable earnings (line 5) greater than

Blind SGA Amount	$ 1,640 ?	______ Yes	______ No
Non Blind SGA Amount	$ 1,000 ?	______ Yes	______ No

(2010 SGA amounts)

- If the answer is No, the customer must apply for Social Security benefits
- If the answer is Yes, the client is engaging in SGA. <u>Deny</u> the MA application.

______________________ Case Manager Signature

______________________ Telephone Number

______________________ Date

Address: ____

____

SUBSTANTIAL GAINFUL ACTIVITY

The law requires that we deduct the cost of certain items and services the disabled person needs in order to work. The cost can be deducted from earnings in SGA determinations even though the items and services are also used for non-work activities.

The amount of Impairment-Related Work Expenses that may be deducted is subject to reasonable limits. Deductions for needed items and services will be made only if the cost is paid by the impaired individual, not by and insurance company, social agency, or other reimbursement.

Example of Impairment-Related Work Expenses

Attendant Care Services:

This includes forms of personal assistance to help an individual meet his or her essential needs at home or at work. Personal assistance includes: bathing, dressing, cooking, eating, communicating and traveling to and from work.

Transportation Costs:

A disabled person may have deductible transportation costs if he or she requires structural or operational modifications to a vehicle in order to drive, or be driven, to work.

The cost of the automobile is not deductible, but if paid by the disabled person, the modifications are. If an agency pays for the modification, then the cost cannot be deducted.

A disabled person might also need to pay for a taxi or pay for an independent driver, and this can be written off because of their inability to use available public transportation.

Medical Devices:

This includes durable medical equipment which can withstand repeated use and is primarily used to serve a medical purpose. These items are generally not useful to a person in the absence of an illness or injury. Examples of medical devices include: wheelchairs, respirators, pacemakers, leg/arm/back braces and similar items.

Work Related Equipment:

This includes equipment which is impairment-related and necessary for the impaired individual to do his or her job. Examples include: vision and sensory aids for the blind and telecommunications devices for the deaf.

Prostheses:

Items included in this category are devices used to replace internal body organs or external body parts. For example: artificial hips, limbs or other body parts. If the replacement is purely cosmetic, the cost is usually not deductible.

Residential Modifications:

This category includes changes made to alter the physical structure or operation of a person's home in order to accommodate his or her functional limitations.

If the person works away from their home, modifications which permit access to the street, such as a ramp or hand rails, are deductible.

If the individual works at home, the costs to modify the interior of the home in order to create a working space compatible to the person's impairment would be deductible to the extent that the modifications pertain specifically to the work space. An example of this would be the enlargement of a doorway leading into an office.

Routine Drugs and Services:

Routine drugs and medical services are deductible if they are needed to control the disability, thus permitting the person to work.

Other Costs:

Similar items or services may also be deductible if they meet the criteria listed above. Examples include:

- Expendable medical supplies such as ace bandages, elastic stockings and face masks.
- Expenses relating to a seeing-eye dog. These expenses may include the purchasing of dog food, licenses and veterinary services.

It is important to remember that if the costs of equipment or home modifications can be deducted by a self-employed individual on their tax return as a business expense, that same cost is not deductible as Impairment-Related Work Expenses.

☐ ABD
☐ X02

☐ Initial Application
☐ Reactivation
☐ Remand as a result of an Appeal

DISABILITY OR BLINDNESS DETERMINATION TRANSMITTAL

PRINT ONLY **Date Referred** _____

I. Client Name: _____
Last First MI

LDSS: _____

District: _____

Social Security #: _____ Case Manager: _____

Client ID #: _____ Telephone #: _____

_____
Application Date

Currently employed: Yes _____ See Attached Earnings Documentation
No _____

_____
Date Required Information was received from the Customer/Representative

II. MEDICAL DETERMINATION

ONSET DATE _____

☐ No Medically Determinable Impairment **(Not Disabled)**
☐ Impairment(s) Not Severe **(Not Disabled)**
☐ Impairment(s) Severe by Not Expected to Last 12 Months **(Not Disabled)**
☐ Meets Listing _____ (cite listing) **(Disabled)**
☐ Equals Listing _____ (cite listing) **(Disabled)**
☐ Impairment(s) Severe by Doesn't Meet or Equal Listing **(See Section III)**
☐ Medical Evidence Needed (Specify in comment section)

COMMENTS: _____

Signatures: MRT OPHTHALMOLOGIST _____ DATE _____
MRT PHYSICIAN _____ DATE _____
MRT PSYCHOLOGIST/PSYCHIATRIST _____ DATE _____

III. MEDICAL VOCATIONAL DETERMINATION

☐ Can Still do Past Relevant Work **(Not Disabled)**
☐ Cannot Make an Adjustment to do Other Work **(Disabled)**

COMMENTS:

Signature: DISABILITY SPECIALIST _____ DATE _____

DHR/FIA 707 (revised 1/09) *Previous editions obsolete.*

WHITE – State Review Team Copy PINK – LDSS Case Record YELLOW – LDSS Control Copy

INSTRUCTIONS FOR FORM DHR/FIA 707

Transmittal for State Review Team

SECTION I

ABD/X02: Place a check (✓) to identify the type of case

Initial Application/Reactivation/Remand as a result of an Appeal: Place a check (✓) in the appropriate box to identify the type of information submitted.

Date Referred: Indicate the date the referral is forwarded to the State Review Team.

Client's Name: **Print Only.**

Social Security Number: Enter the client's Social Security Number.

Client ID: Enter Customer's Client ID.

LDSS/District: Enter the appropriate Local Department Name and District Office Number.
(Do Not Abbreviate)

Case Manager/Telephone: Indicate the case manager's first and last name assigned to the case and the corresponding telephone number. **(Do Not Abbreviate)**

Application Date: Date of Initial Application.
Date Required Information was received: Date **all** required information was received by the local department from the Customer/Representative

Currently Employed: Check yes or no. If yes, attach the appropriate earnings verification (Refer to the Medical Assistance policy manual)

SECTION II

THIS SECTION IS FOR DISABILITY REVIEW TEAM USE ONLY

ONSET DATE: For the purpose of the Medical Assistance disability determination, this date represents the earliest date the individual's medical condition met the definition of disabled based on the medical evidence obtained.

SECTION III

THIS SECTION IS FOR REVIEW TEAM USE ONLY

FORMS DISTRIBUTION:
1 copy – State Review Team (White)
1 copy – Local Department Case Record (Pink)
1 copy – LDSS Control Copy (Yellow)

DISABILITY REPORT – Form DHR/FIA – 3368
COMPLETING THIS FORM

THIS IS NOT AN APPLICATION

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability determination.

- Please fill out as much of this form as you can.
- Print clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer, or the answer is "none" or "does not apply," please write: "don't know" or "none" or "does not apply."
- **IN SECTION 4, PUT INFORMATION FOR ONLY ONE DOCTOR/THERAPIST/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for Medical Assistance benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Page 9 and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for Medical Assistance benefits, send them to our office with your completed forms or bring them with you to your interview.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

If you need the records back, tell us and we will photocopy them and return them to you.

DISABILITY REPORT

For Local Department and State Review Team use Only
Do not write in this box.

Client ID# _____

Medical Assistance AU# _____

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** (First, Middle Initial, Last)

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

_____ _____ (Your Number (Message Number
Area Code Number

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help with your application.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ _____ _____ DAYTIME PHONE _____ _____
City State Zip Area Code Number

E. What is your **height** without shoes? _____ feet _____ inches

F. What is your **weight** without shoes? _____ pounds

G. Have you applied for Social Security benefits? ☐ NO ☐ YES If **YES** when:

MONTH	DAY	YEAR

H. Can you **speak and understand English?** ☐ YES ☐ NO

If you cannot **speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO (If "YES", and that person is the same as in "D" above write "SAME" here: _____ . If not, complete the following information.)

NAME _____ **RELATIONSHIP** _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ _____ _____ **DAYTIME PHONE** _____ _____
City State Zip Area Code Number

I. Can you **read and understand English?** ☐ YES ☐ NO

J. Can you **write more than your name in English?** ☐ YES ☐ NO

K. Can you Speak English? ☐ YES ☐ NO

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work?

B. How do your illnesses, injuries or conditions limit your ability to work?

C. Do your illnesses, injuries or conditions cause you **pain** or **other symptoms**? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first interfere with your ability to work?**

MONTH	DAY	YEAR

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

MONTH	DAY	YEAR

F. Have you **ever worked?** ☐ YES ☐ NO (If "NO," go to Section 4.)

G. Did you **work at any time** after the date of your illnesses injuries or conditions first interfered with your ability to work? ☐ YES ☐ NO

H. If "YES", did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now?** ☐ YES ☐ NO

If "NO," when did you stop working?

MONTH	DAY	YEAR

J. Why did you stop working?

SECTION 3 – INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE (Example: Cook)	TYPE OF BUSINESS (Example: Restaurant)	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (per hour, day, week, month or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & down & forward.)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on Hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other _____

H. Check weight **often** lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

I. Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(If No, go to J.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5

C. List other names you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE ____ Area Code ____ Phone Number		PATIENT ID # (if known)	NEXT APPOINTMENT
REASON FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

2.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE ____ Area Code ____ Phone Number		PATIENT ID # (if known)	NEXT APPOINTMENT
REASON FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

DOCTOR/HMO/THERAPIST/OTHER

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

3.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE Area Code ____ Phone Number ____		PATIENT ID # (if known)	NEXT APPOINTMENT
REASON FOR VISITS ____			
WHAT TREATMENT WAS RECEIVED? ____			

If you need more space, use Section 9

E. List each HOSPITAL/CLINIC. Include your next appointment.

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS				DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATE OF VISITS	
PHONE Area Code ____ Phone Number ____			☐ EMERGENCY ROOM VISITS		

Next appointment ____

Reasons for visits ____

What treatment did you receive? ____

What doctors do you see at this hospital/clinic on a regular basis? ____

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS
List any Hospital/Clinic that may have your medical records

HOSPITAL/CLINIC

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS				DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATE OF VISITS	
PHONE ____ Area Code ____ Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES (If "YES," complete information below.) ☐ NO

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE ____ Area Code ____ Phone Number		PATIENT ID # (if known)	NEXT APPOINTMENT

CLAIM NUMBER (If any) _____

REASON FOR VISITS _____

If you need more space, use Remarks, Section 9.

SECTION 5 – MEDICATIONS

Do you currently take any medications for your illnesses, injuries or conditions? ☐ YES
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 – TEST

Have you had, or will you have any medical test for your illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	DATE WHEN DONE, OR WHEN IT WILL BE DONE? (Month, day, year)	WHERE WAS IT DONE? (Name of Hospital/Clinic)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY – Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY – Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other test, list them in Remarks, Section 9.

SECTION 7 – EDUCATION/TRAINING INFORMATION

A. Check the highest grade of school completed.

Grade school:

0	1	2	3	4	5	6	7	8	9	10	12	GED
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

College:

1	2	3	4 or more
☐	☐	☐	☐

Approximate date completed: _____

B. Did you attend special education classes? ☐ YES ☐ NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____
City State Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of special job training, trade or vocational school?
☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 – VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support
- an individualized education program through an educational institution (if a student age 18 – 21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____
City State Zip

DAYTIME PHONE NUMBER _____ _____
Area Code Phone Number

DATES SEEN _____ TO _____

TYPES OF SERVICES OR TEST PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 – REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to complete the information at the bottom of this page.

If the person completing this form is someone other than the disabled person or the person identified in Section 1, Item D, please complete the following information

Name of person completing this form if other than the disabled person *(Please Print)*	**Date Form Completed** *(Month, day, year)*
Address (Number and street)	**e-mail address** *(optional)*
City **State**	**Zip Code**

Relationship to Disabled Person	**Daytime Telephone Number** ( ) -

WHOSE Record to be Disclosed	
Name (First, Middle, Last)	
SSN - -	Birthday (mm/dd/yy)

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF HUMAN RESOURCES (DHR) FAMILY INVESTMENT ADMINISTRATION (FIA) STATE REVIEW TEAM (SRT)

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, Acquired Immune Deficiency Syndrome (AIDS): and tests for HIV.
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Plans (IEP), trienneial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by FIA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX IS TO BE COMPLETED BY SRT Additional information to identify the subject (e.g., other names used) the specific sources, or the material to be disclosed:

TO WHOM **The Department of Human Resources and to the State agency authorized to process my case** (usually called "Family Investment Administration"), **including contract copy services, and doctors or other professionals consulted during the process**

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the definition of disability.

EXPIRES WHEN This authorization is good for 12 months from the date signed that appears below.

- I authorize the use of a copy (including electronic copy) of this form for disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to FIA and my sources to revoke this authorization at any time (see page 2 for details).
- FIA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure** **SIGN →**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) **SIGN HERE:**

Date Signed	Street Address		
Phone Number (with area code)	City	State	Zip

WITNESS I know the person signing this form or am satisfied of this person's identity:
SIGN → (OPTIONAL)

Phone Number (or Address)	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA") 45 CFR parts 160 and 164.42 U.S. Code section 290dd-2: 42 CFR part 2; 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; Md. Code Ann., Human Services Art. §1-201, Health-General Art.§§4-302-03 and 4-307.

Explanation of Form DHR/FIA 827,

"Authorization to Disclose Information to the State Review Team"

We need your written authorization to help get the information required to process your application. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form DHR/FIA 827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. Some individual sources of information require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any item, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to your local department of social service office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. FIA can tell you if we identified any sources you didn't tell us about. FIA may use information disclosed prior to revocation to determine your eligibility for benefits.

IMPORTANT INFORMATION REGARDING CONFIDENTIALITY

All personal information collected for FIA is protected by Maryland law, including Md. Code Ann., Human Services Art. § 1-201, as well as federal law. Once medical information is disclosed to FIA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). FIA retains personal information in strict adherence to the retention schedules established and maintained as required by Md. Code Ann., State Gov't Art. § 10-611 *et seq.*

The State of Maryland, through DHR/FIA, is authorized to collect the information on form DHR/FIA-827 by section 1902 of the Social Security Act, which sets forth the requirements for states administering the Medical Assistance program. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits. This usually includes review of the information by the State agency processing your case and quality control people in DHR. In some cases, your information may also be reviewed by DHR personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your application, and could result in denial or loss of benefits. Although the information we obtain with the form is almost never used for any purpose other than those stated above, the information may be disclosed by DHR without your consent if authorized by Federal and State laws. For example, DHR may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist DHR to establish rights to benefits and/or coverage;
2. Pursuant to law authorizing the release of information from DHR records;
3. For statistical research and audit activities necessary to ensure the integrity and improvement of DHR programs.

DHR will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, (2) from educational records for a minor obtained under 34 CFR part 99, Family Educational Rights and Privacy Act (FERPA), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

MARYLAND DEPARTMENT OF HUMAN RESOURCES

311 West Saratoga Street
Baltimore, Maryland 21201-3521

_____ DEPARTMENT OF SOCIAL SERVICES

Name: _____

Address: _____

_____ Client ID: _____

DISABILITY DETERMINATION NOTICE OF ACTION

In deciding whether your illness or injury is disabling, the State Review Team (SRT) reviewed medical and other evidence received from all available sources. After careful review of this evidence, SRT has determined that your condition is not disabling.

Enclosed is an SRT Medical, Vocational, Educational Assessment stating the reason (s) for the decision.

If you do not agree with this decision, you have the right to request a HEARING. You also have the right to re-apply.

_____
CASE MANAGER SIGNATURE

_____
CASE MANAGER PHONE NUMBER

_____
DATE OF NOTICE

MARYLAND DEPARTMENT OF HUMAN RESOURCES
STATE REVIEW TEAM
311 W. SARATOGA STREET
BALTIMORE, MD. 21201-3521

MEDICAL, VOCATIONAL, EDUCATIONAL ASSESSMENT

NAME: **AGE:**

SS# **HEIGHT:**

Client ID # **WEIGHT:**

Dear ,

The State Review Team uses the Social Security Disability criteria to determine disability. The Social Security Administration defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

In deciding whether your impairment is disabling, the State Review Team (SRT) used the medical and social information you submitted, and when required information from a consultative examination. The following summary gives the reasons for the decision in your case.

STEP TWO: Do you have a severe medically determinable impairment(s)?

A severe impairment is defined as any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities. Basic work activities mean the abilities and aptitudes necessary to do most jobs. Pain must be considered as a factor that may limit the performance of one or more of the functions listed below. Examples of this include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying or handling;
2. Capacities for seeing, hearing and speaking;
3. Understanding, carrying out and remembering simple instructions;
4. Use of judgement;
5. Responding appropriately to supervision, co-workers and usual work situation; and
6. Dealing with changes in a routine work setting.

See 3368 form for medical history.

Based on the information received by the SRT the answer is:

( ) YES, continue to STEP THREE

( ) NO, go to DISABILITY DETERMINATION on last page.

STEP THREE: Does your impairment(s) meet or equal a listing of impairment?

The listing of impairments are specific mental or physical health problems described in the Social Security Regulations. The severity of your impairment(s) is assessed against the listings of impairments to determine if you meet or equal the listings. Additional listings of impairments can be found at 20 C.F.R. PT. 404. SUBPT, P. APP. 1

The medical documentation received by SRT shows the following:

Diagnosis:

Medical findings: See medical documentation.

Signs and symptoms: See medical documentation.

Based on the information received by the SRT the answer is:

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, continue to STEP FOUR

Rationale: There was not sufficient medical evidence to support the above ailments as totally disabling impairments under the Social Security's regulations.

_____

Disability Specialist Signature

STEP FOUR: Can you return to past relevant work?

Past relevant work is the kind of work that you have performed (See 3368 form).

The medical documentation received by SRT shows the following:

Physical residual functional capacity assessment:

Mental residual functional capacity assessment:

Residual functional capacity from environmental or other medically determinable impairment(s):

Residual functional capacity from a combination of medically determinable impairment(s):

Exertion level:

Based on the review of this information SRT answered the following:

Do you meet the criteria for first adverse profile (rule I)?

You must have a severe impairment which prevents work at customary level of physical exertion, have 35 years or more of arduous, physical, unskilled work and a marginal education – sixth grade or less.

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, do you meet the criteria for second adverse profile (rule II)?

You must have a severe impairment, advanced age (55 years or older), limited education (11th grade or less) and no relevant work experience.

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, if NO answer the following question.

Can you return to past relevant work?

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, proceed to STEP FIVE

STEP FIVE: Can you perform any other work that exists in the national economy?

The medical documentation received by SRT shows the following:

Assessment of vocational factors:

Age:

Educational level:

Previous work experience:

Do any grid rules apply (exertional impairments only):

Citations of three jobs you should be able to perform from the Dictionary of Occupational Titles:

DISABILITY DETERMINATION: The disability or vocational specialist's determination is you are:

( ) DISABLED ( ) NOT DISABLED

Specialist's Initials	Date	SRT Approval	Date

EMERGENCY SERVICES TO INELIGIBLE ALIENS

Date: _____

TO: Beneficiary Services Administration
Office of Operations & Eligibility
201 West Preston Street
Baltimore, MD 21201

FROM: Local
Department _____
Medical Assistance Unit

Unit
Address: _____

_____

_____

SUBJECT: Determination of Emergency Services – Aliens

Case Name: _____

Case Number: _____

Date of MA Application: _____

I have checked and agree that the technical and financial information for the applicant has been reviewed and meets the MA requirements except for citizenship.
Caseworker
Signature: _____
(Please sign your name)

The above-named applicant has submitted a Medical Assistance application for coverage. of emergency services received _____ (date) to _____ (date) at _____ from

Federal category for which the applicant is eligible, but for his/her alien status:
☐ FAC ☐ MCHP ☐ Aged ☐ Disabled/Blind

A copy of the following must be attached:

- ☐ MMIS screen 1 or MMIS/CARES screen showing results of search
- ☐ Discharge summary with admission and discharge dates
- ☐ ER admission
- ☐ Documentation showing the emergency nature of the medical services
- ☐ SRT determination (if qualifying as disabled/blind)

***Note: No bills or other extraneous information should be submitted.**